DOCUMENT RESUME

ED 448 553 EC 308 167

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TITLE Slipping on the Ice: The Relationship between Verbal Skills, Aggression, and Self-Esteem in Men with Cerebral Palsy and Mental Retardation.
PUB DATE 2000-06-01
NOTE 17p.; Paper presented at the Annual Meeting of the American Association on Mental Retardation (12th, Washington, D.C., May 30-June 3, 2000).
PUB TYPE Information Analyses (070) -- Reports - Research (143) -- Speeches/Meeting Papers (150)
EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Adults; *Aggression; Behavior Change; *Behavior Modification; *Cerebral Palsy; *Counseling Techniques; *Depression (Psychology); Etiology; Individual Characteristics; Influences; Males; *Mental Retardation; Multiple Disabilities; Predictor Variables; Self Esteem; Symptoms (Individual Disorders)

ABSTRACT

This paper discusses the occurrence of challenging behaviors in adult men dually diagnosed with cerebral palsy and mental retardation, the dynamics that underlie problematic interactions with staff and peers, and strategies with which to address these behaviors. The vicious cycle that occurs when a client with cerebral palsy and mental retardation responds aggressively to a perceived provocation of a staff member, resulting in a punitive response from the support person, is described. Risk factors for aggressive behavior are also identified, including the presence of an organized brain syndrome, a history of institutionalization, being male, and a previous history of aggression. The need to treat aggressive clients for possible depression and low self-esteem is emphasized. The paper concludes with three clinical vignettes that illustrate the types of problems and obstacles that often confront men with cerebral palsy. All three men were being treated with medication to address their aggression, as well as with behavioral programming, and yet were still manifesting aggressive behaviors on a regular basis. Counseling focusing on active and empathetic listening, teaching of relaxation techniques, group counseling, and individual counseling resulted in decreased aggression, improved peer relationships, and increased self-esteem. (Contains 26 references.) (CR)

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Presented at the AAMR National Meeting
Washington, DC, June 1, 2000

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SLIPPING ON THE ICE

The Relationship Between Verbal Skills, Aggression and Self-Efficacy in Men with Cerebral Palsy and Mental Retardation

Adult males diagnosed with cerebral palsy and mental retardation are often perceived by support persons as angry, aggressive, even dangerous individuals. Such persons may face multiple challenges related to communication skills and physical mobility. Gender roles and resulting societal expectations which dictate a standard of manhood which is based on the able-bodied paradigm can result in frustration and feelings of inadequacy, leading to situations in which conflicts with peers and staff occur. Such conflicts not infrequently include elements of verbal or physical aggression. Research and clinical experience suggest that an increase in such an individual's ability to appropriately, verbally express a variety of emotions may result in a reduction in the number of incidents of aggressive behavior as well as in enhanced psychosocial functioning.

Adult men dually diagnosed with cerebral palsy and mental retardation are often characterized as angry, aggressive, even dangerous individuals by staff, caregivers, and others who support and interact with them. This view has a variety of potentially negative consequences for such persons. The purpose of this paper is to discuss (1) the occurrence of challenging behaviors, specifically verbal and physical aggression, in this population, (2) the psychological, emotional, and social dynamics which underlie problematic interactions with staff and peers, and (3) to identify strategies with which to address these behaviors.

Individuals in whom cerebral palsy coexists with mental retardation may face serious challenges in terms of their ability to communicate effectively, as well as in the area of physical mobility, which is often significantly impaired. For men, gender role expectations, in which manhood is defined by the able-bodied societal paradigm, can add significantly to their sense of frustration. They (and we as well) are told both overtly and subtly that men are strong, active, and in control of both their bodies and their emotions. When one's reality is that of living with significant physical and mental disability, the resulting dissonance can be significant. This of course speaks as much to the social construction of disability, as it does to the physical impairment. Susan Wendell puts it well when she explains that "we idealize the human body. Our physical ideals change from time to time, but we always have ideals. These ideals are not just about

appearance; they are also ideals of strength and energy and proper control of the body" (1997, p. 267).

Men with cerebral palsy and intellectual disabilities may manifest symptoms of organic mood disorders, and often are labeled, sometimes appropriately and sometimes not, with such diagnoses as Impulse Control Disorder and Intermittent Explosive Disorder. They may be perceived as violent or unpredictable, and are often described somewhat pejoratively as "having a short fuse" or as being a "loose cannon." Caregivers and service providers, typically overworked and underpaid, may have difficulty summoning the patience and empathy required to listen to and understand the needs and desires of clients such as these.

The client-staff interactions which appear to be most problematic and hostile usually revolve around issues of control and respect. It is also not unusual for workers to view such men as children who must be told "what to do and when to do it." It is all too common for a program aide or developmental trainer to snap out orders, forgetting that the person to whom he or she is speaking is an adult. The co-existence of cognitive limitations with physical disability may obscure the reality of an adult with a strong need for respect, as well as for control over the decisions which impact upon the quality of his life. All of these factors may combine to create a situation in which frustration and feelings of inadequacy are inevitable, and conflicts with staff, peers, and, especially, authority figures are common, often including an element of verbal or physical aggression.

Interactions between such clients and their staff or caregivers often resemble the proverbial "vicious circle." The client responds to what he perceives as a provocation on the part of the staff. He reacts with anger, possibly with aggression. This elicits an angry or punitive response from the support person. Often as a result of these negative interchanges, the client acquires a reputation for being a difficult individual, and as such may be denied opportunities and experiences for which he is otherwise qualified. For

example, an "aggressive" man may not have the option of being considered for desirable residential or vocational placements, on the grounds that his behavioral challenges cannot be accommodated. The harsh reality is that there are often far more individuals in need of appropriate housing and employment opportunities than can be served. Competition is fierce for the available openings, and they are most often offered to individuals who do not manifest behaviors which are disruptive or dangerous. Learning to manage anger and aggression is therefore imperative for such men, not only to prevent injury to self or others, but also to permit them to achieve a maximum degree of self-efficacy, self-determination, and autonomy.

Research suggests that aggressive behavior is a serious problem for society in general, as well as for the population of developmentally disabled adults in particular. Novaco, in his work on anger as a clinical and social problem, points out that aggressive behavior is by nature destructive to the well-being of both the community and the individual (Novaco, 1986). In general, aggression occurs in response to anger (Novaco, 1986; Benson, 1992). While anger is a part of the normal and healthy range of human expression, it becomes a problem for the individual and for others when it is a precursor to aggression. Novaco (1986) points out that anger is associated with certain clinical conditions, some of which, such as organic brain dysfunction resulting in impaired cognitive abilities, have particular relevance to the population which is the subject of this paper.

Studies of aggression in adults with mental retardation identify several risk factors for this behavior. In general, level of cognitive functioning is negatively correlated with likelihood of aggression. The presence of an organic brain syndrome, also appears to predispose an individual toward aggressive acting out (Barnhill, 1999). Other identified risk factors include a history of institutionalization, previous history of aggression, and being male, with previous history of aggression being the strongest predictor (Davidson, et al., 1994). The same authors suggest that there is a complex

interaction between central nervous system functioning and developmental, cognitive, and social factors which contribute to aggressive behavior in adults with developmental disabilities.

Research which has investigated the reasons for aggressive behavior in persons with developmental disabilities has indicated that there are several possible approaches to understanding the social, medical, and psychological factors which contribute to such behavior. Pfadt (1997) suggests that in addition to functional analysis, which views aggression from the perspective of an outside observer, such behavior should be evaluated in terms of its communicative intent, as well as in terms of the subjective meaning which it may have for the individual. Recent literature suggests that persons with mental retardation who manifest aggressive behavior may differ in significant ways from their non-aggressive peers in terms of their ability to correctly interpret the intentions of others. A study by Pert, Jahoda, & Squire (1999) looked at cognitive factors as mediators of aggression in people with mental retardation. They found that in ambiguous interpersonal situations, mentally retarded adults with a history of aggressive behavior were more likely than those without such a history to display a hostile bias in interpreting such ambiguous situations. A study of labeling and discrimination of facial expressions by aggressive and nonaggressive men with mental retardation (Walz & Benson, 1996) resulted a similar finding--that aggressive men with mental retardation have a negative emotional bias for facial expressions which are ambiguous. A similar bias was not found in a control group of non-aggressive men with mental retardation.

A study by Fuchs & Benson (1995), in which social information processing by aggressive and nonaggressive men with mental retardation was studied revealed that, contrary to expectations, there was no difference between the two groups in terms of their ability to generate multiple solutions or responses to interpersonal problems and concerns. The two groups did, however, differ significantly in two other areas, with the aggressive men identifying a larger number of aggressive *responses*, as well as showing a

tendency to more often give an aggressive response as the *first* response to a perceived provocation. Benson (1992) suggests that deficits in problem-solving skills and feelings of frustration may also predispose an individual with developmental disabilities to engage in aggressive behavior when confronted with frustrating or stressful environmental conditions. She suggests that using a cognitive behavioral model of anger arousal is helpful in understanding anger and aggression in this population. Reiss (1994), while recognizing that some anger and resultant aggression are situationally determined, stresses the importance of other factors such as social learning, genetic anomalies, personality factors, and psychopathology.

Aggressive behavior in the population of persons with developmental disabilities is a common and serious concern for those who provide services to these individuals, as well as to family members and others who have close contact with such persons. Spragg (1993) refers to the negative consequences which attach to a label of "dangerousness" which is often applied to persons with mental retardation who display aggression. Matson and Gorman-Smith (1986) discuss the disruption caused by aggressive behavior in the home, the workplace, and in the larger community. They also mention the obvious risk of injury to the aggressive person or to others, as well as the impediment to placement in a less restrictive environment. The impact on vocational opportunities, including the likelihood of community-based employment is mentioned by Gardner & Moffet (1990), as well as the risk of abuse to the aggressive individual as a result of his or her behavior and the possibility of restricted social opportunities. An article by Belcher (1995) concerning aggressive behavior in a day program for mentally retarded adults provides a perspective which is virtually unique in the literature. Belcher (1995) describes two men with mental retardation who manifested high levels of aggression in a sheltered workshop setting, whose aggressive behavior declined by 93% when they were placed in community employment settings and provided with intensive behavioral supports, of which counseling was a part.

For social workers and other clinicians treating persons with aggressive behavior, the relationship between aggression and depression should not be overlooked. Depression is a commonly occurring psychiatric disorder in persons with developmental disabilities and may present with a wide variety of symptoms, including irritability and aggressive outbursts (Myers, 1998; Rudich & Alamir, 1999). Benson (1992) explains that in addition to being exposed to a variety of psychosocial stressors, many people with cognitive disabilities have difficulty with self-expression, and may be unable to verbally express their dysphoric feelings. She suggests that this may help to explain the association between depression and aggressive behavior in persons with developmental disabilities. Hurley & Hurley (1986) suggest that depression in persons with developmental disabilities can be understood as a reaction to the emotional conflicts which result from the desire to achieve certain things which society considers normative, and which they are unable to achieve because of cognitive deficits and insufficient social skills. Gaedt (1997), on the other hand, views depression in persons with developmental disabilities from an object relations perspective, arguing that the struggle for separation and autonomy, which is resolved with difficulty, if at all, in persons who are cognitively impaired, results in persistent depressive reactions. This seems particularly relevant for people who are both physically and cognitively disabled, and for whom independence and autonomy are frequently elusive.

Self-esteem is another area of psychosocial functioning which must be considered in providing mental health services to adults with developmental disabilities. Given the highly negative way in which people with developmental disabilities are regarded, lower levels of self-esteem would be expected in this group of people than in the general population. Research conducted by Jahoda, et al. (1998) suggests that low levels of self-esteem may be linked to aggressive behavior in persons with intellectual disabilities. Their study comparing aggressive and non-aggressive people with mental retardation showed that participants who tended to display aggressive behavior felt a lack

of self-efficacy in stressful situations and perceived others as treating them in a derogatory manner.

Providing social work services to men with cerebral palsy and mental retardation who display aggressive behavior while challenging, also presents the worker with an opportunity to significantly impact in a positive way on the life of the client. Counseling, combined with strong advocacy within the client's support system has been, in my experience, an effective combination. Historically, counseling and psychotherapy have been underutilized with adults with developmental disabilities. Reiss (1994) argues persuasively that persons with mental retardation have been underserved regarding their mental health needs, even though such individuals are at higher risk for mental disorders than the population as a whole. Reiss's concept of "diagnostic overshadowing," refers to the lack of attention paid to symptoms of mental disorders in persons with mental retardation, and the concomitant attribution of any such symptoms to the person's mental retardation. In his view, this has contributed significantly to the lack of mental health services offered to the developmentally disabled population. In recent years, the term "dual diagnosis" has been used increasingly to describe people in whom mental illness coexists with mental retardation (Prout & Strohmer, 1998). Several articles published within the last few years have indicated that psychotherapy can be an effective intervention with persons with developmental disabilities (Deutsch & DiMatteo, 1997; Keller, 1997; Levitas, 1997; Perkins, 1993; Perkins, 1999).

I would like to conclude this paper with three brief clinical vignettes which illustrate the types of problems and obstacles which often confront men with cerebral palsy and mental retardation and the benefits which can accrue to them from thoughtful and appropriate social work interventions. Each of the three men whose stories I will touch upon were referred to me for counseling as a "last resort." All three were being treated with medication to address their aggression, as well as with behavioral programming, and yet were still manifesting aggressive behaviors on a regular basis.

Robert

Robert is a man in his 40's with moderate mental retardation and cerebral palsy. His ability to communicate verbally is quite limited due to his cerebral palsy, which renders his speech difficult for most people to understand. Robert's problematic aggressive behavior was usually in evidence when something occurred which triggered his fears of abandonment. Robert had been literally abandoned by his family as a young child and had suffered greatly over the years when favorite staff or volunteer workers left his life. A canceled outing with a volunteer or an emergency which caused his QMRP to unavailable for a regularly scheduled "talk time" could trigger an aggressive episode. The incident which resulted in Robert's referral for counseling involved his throwing a can of pop at a male staff member with such force that the man required treatment in the emergency room.

Counseling with Robert focused upon active and empathic listening, as well as the teaching of relaxation techniques which Robert could employ to self-soothe when he began to feel upset. As trust developed, Robert began to feel that talking to someone who listened and tried to understand his distress and frustration could help him to avoid acting out aggressively. Working with Robert and his QMRP, several staff persons at both his residence and his workshop were identified as persons to whom Robert could go to talk when he was sad, frustrated, or angry. As the number of Robert's incidents of aggression declined, he was viewed as more approachable and reasonable by staff, who previously had avoided him or antagonized him by appearing to be insensitive to his feelings. Robert's peer relationships improved, as did his self-esteem, as he gained more control over his emotions and more skill in communicating with others.

Norm

Norm is a man in his 30's with cerebral palsy and mild mental retardation. His speech is relatively unimpaired and his verbal skills are generally good. However, his gait and the use of his left hand are strongly affected by his disability. Norm is very

concerned with appearing strong and manly and has a girlfriend whom he has been seeing for several years. He has expressed a strong interest in becoming a police officer or security guard. Norm's problems with staff centered around his desire to have time alone with his girlfriend and his general "noncompliance"--Norm doesn't like to follow orders. Group counseling in a peer support group which emphasized social skills and problem-solving was helpful for Norm, as was time-limited relationship counseling with Norm and his girlfriend. Facilitating Norm's appointment to the Resident's Council provided him with a meaningful leadership role in the context of his daily life. Additionally, while participating in group counseling, Norm developed skills in helping peers to problem-solve and to identify appropriate solutions which could be used to resolve difficulties. In assisting his friends, Norm also helped himself. Norm's propensity to act out aggressively lessened over time, as he began to feel that he had more resources, both external and personal, at his disposal.

Bob

Finally, I would like to discuss Bob, whose story inspired the title of this paper. Bob is a man in his 30's with whom I worked for four years. He is a short-statured man, with moderate mental retardation and cerebral palsy resulting from a head injury he sustained as an infant when he fell from his changing table. His speech can be difficult to understand for people who either don't know him well or who don't take the time to listen carefully. Bob wears braces on his legs and ambulates slowly with the aid of a tripod cane. He requires assistance to rise from a seated position and his balance is precarious. Because of the severity of his disability, such activities of daily living as shaving, bathing and dressing cannot be performed alone. Thus Bob needs help of an extremely personal nature from staff or caregivers on a daily basis.

Bob was referred for counseling because of problems he was causing for the staff in both the residential and the workshop setting. He was described as being aggressive and non-compliant, and was widely seen as being both unpredictable and dangerous.

Despite having severely limited mobility and impaired coordination, Bob had a history of attacks upon staff which included biting, scratching, and hitting, as well as threatening people with his cane. Many staff persons admitted to being frightened of Bob and acknowledged that they tried to avoid working with him.

Working with Bob in individual counseling was both challenging and ultimately extremely rewarding. Once a degree of trust was established, I learned that typically the incidents which provoked an aggressive reaction in Bob were the sorts of things which would make *most* people angry. For example, watching certain television shows, especially baseball games, was extremely important to Bob. He repeatedly had the experience of seeing a staff member come into the residents' lounge and change the channel to a soap opera or talk show that was of interest to him or her, completely disregarding the fact that Bob was engrossed in a program.

Bob also repeatedly told me that when he resorted to biting or scratching someone, it was because that person was, in Bob's words, "in my face." Bob meant this literally--he had little tolerance for people invading his personal space and this happened to him on a regular basis. This was in part an inevitable consequence of the fact that his disability necessitated that he receive a great deal of help which involved touching and other close contact. However, he did not react to everyone in the same way, and it became clear that staff who approached him with respect were not attacked by Bob. He simply wanted to be told what was happening, and to be given some choice about such mundane decisions as what clothes he wore and whether he would shave before or after breakfast. These are the sorts of decisions that most of us make many times daily and take completely for granted. Helping Bob to identify and practice appropriate ways to verbally express his preferences, combined with meetings with his QMRP and other staff members to sensitize them to Bob's perception of the problem, helped to bring about an improvement in Bob's ability to manage his aggressive impulses.

Bob's goal, which he began to express early in the counseling process, was to move out of the 97 bed ICF where he was residing. Bob believed that living in a large facility with 96 other people was not the best setting for him. He wanted very much to be in a more home-like setting, and one in which he didn't have to negotiate long, crowded hallways to get from his bedroom to the dining room or the lounge.

An incident involving Bob's father which was discussed in an annual staffing review proved to be a turning point for Bob in terms of his ability to control his aggressive impulses, and which eventually led to Bob's being accepted as a resident in a small CILA. During the incident in question, Bob had been physically aggressive toward his father at the end of a home visit. Bob's father had asked him to get ready to return to the ICF. Bob refused, but gave no reason for his refusal. When his father insisted, Bob tried to bite his dad. The two men have a generally close and positive relationship, and this occurrence was both out of character for Bob and very troubling to his father. When Bob and I discussed this in our counseling session, Bob revealed what he had not told his father--that because it was a snowy night and the sidewalks were slippery, he was afraid of losing his balance and falling. As this was explored in more detail, Bob also confided that this fear of falling was a factor in his being late for meals, programming, and workshop assignments. He preferred to wait until the other clients were out of the hallways, as he was afraid of being bumped or pushed and thus falling down and being either injured or embarrassed.

In talking with Bob about what might be done to alleviate his anxieties about falling, we determined that a new pair of boots which he would select himself, with good traction and other features of importance to him, would provide him with confidence in walking outside in the winter. This was accomplished, with the result that Bob knew he had been heard and that his needs and wishes respected. This was instrumental in laying the groundwork for the accomplishment of Bob's goal of moving into a smaller residential setting. He had previously been told that his history of aggression made him

ineligible for such placement. However, with his new skills in expressing himself verbally, combined with his belief that it would actually be more effective than an aggressive response to frustration, Bob was able to establish to the satisfaction of the service provider that aggressive behavior was no longer a significant problem. Bob moved to a CILA, is doing well in that setting, and is quite satisfied with his current situation. All of us who provide supports for men like Bob would do well to avoid slipping on the ice ourselves by failing to understand the unique meaning *for each individual* of his actions, however problematic they may seem to others. To the extent that we can view what are commonly termed "maladaptive behaviors" as attempts at communication, rather than simply as behaviors to be eradicated, we are in a position to advocate for and empower our clients.

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